FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026773

Facility Name: Parents & Friends of the SLC

Address: 1450 Caseyville Avenue (Number) Swansea (City) 62226 (Zip Code)

County: St. Clair

Telephone Number: 618-277-7730 **Fax #** 618-277-5423

IDPA ID Number: 37-1089886005

Date of Initial License for Current Owners: 1/1/1982

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code 501 C-3		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Shirley Saia **Telephone Number:** 618-277-7730 ext. 3309

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Chad M. Rollins

(Title) Executive Director

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 0101/05 Ending: 123105

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	100	Intermediate/DD	100	36,500	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,500	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	30,060	86		30,146	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,060	86		30,146	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.59%

D. How many bed-hold days during this year were paid by the Department?
204 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/1982

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified and days of care provided

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year:

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Parents & Friends of the SLC # 0026773 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	201,032	20,069	9,054	230,155		230,155		230,155			1
2	Food Purchase		160,039		160,039		160,039		160,039			2
3	Housekeeping	139,661	20,558	7,910	168,129		168,129		168,129			3
4	Laundry		8,341	22,416	30,757		30,757		30,757			4
5	Heat and Other Utilities			111,730	111,730		111,730		111,730			5
6	Maintenance	63,363	18,153	654	82,170		82,170		82,170			6
7	Other (specify):*											7
8	**TOTAL General Services**	404,056	227,160	151,764	782,980		782,980		782,980			8
	B. Health Care and Programs											
9	Medical Director			16,080	16,080		16,080		16,080			9
10	Nursing and Medical Records	1,751,558	54,442	57,606	1,863,606		1,863,606		1,863,606			10
10a	Therapy	16,565			16,565		16,565		16,565			10a
11	Activities	32,726	8,445		41,171		41,171		41,171			11
12	Social Services	23,304		1,440	24,744		24,744		24,744			12
13	CNA Training	92,374			92,374		92,374		92,374			13
14	Program Transportation		16,522		16,522		16,522		16,522			14
15	Other (specify):* seamstress/sewing exp	9,267	1,406		10,673		10,673		10,673			15
16	**TOTAL Health Care and Programs**	1,925,794	80,815	75,126	2,081,735		2,081,735		2,081,735			16
	C. General Administration											
17	Administrative	76,383		1,160	77,543		77,543	(1,160)	76,383			17
18	Directors Fees											18
19	Professional Services			21,364	21,364		21,364		21,364			19
20	Dues, Fees, Subscriptions & Promotions			13,101	13,101		13,101	(2,150)	10,951			20
21	Clerical & General Office Expenses	122,550	24,270	17,500	164,320		164,320		164,320			21
22	Employee Benefits & Payroll Taxes			523,874	523,874		523,874		523,874			22
23	Inservice Training & Education			3,171	3,171		3,171		3,171			23
24	Travel and Seminar			3,676	3,676		3,676		3,676			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			71,197	71,197		71,197		71,197			26
27	Other (specify):*				1,927		1,927	(1,927)	(1,927)			27
28	**TOTAL General Administration**	198,933	24,270	655,043	880,173		880,173	(5,237)	873,009			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,528,783	332,245	881,933	3,744,888		3,744,888	(5,237)	3,737,724			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Parents & Friends of the SLC #0026773 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			153,800	153,800		153,800		153,800			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			153,800	153,800		153,800		153,800			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			235,046	235,046		235,046		235,046			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			235,046	235,046		235,046		235,046			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,528,783	332,245	1,270,779	4,133,734		4,133,734	(5,237)	4,126,570			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 1/1/2005 Ending: ######

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(1,160)	C17		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(2,150)	C20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,927)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (5,237)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (5,237)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Parents & Friends of the SLC

ID# 0026773

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Parents & Friends of the SLC **#** 0026773 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Parents & Friends of the SLC **#** 0026773 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		H.O.M.E. #2	Fairview Heights	SLC Enrichment	Swansea	To provide
		H.O.M.E. #1	Swansea	Center		recreational
						opportunities to the
						severe & profound
						mentally disabled
						adult.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 1/1/2005 Ending: ######

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 01/001/05 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/A											6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	N/A											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Parents & Friends of the SLC # 0026773 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important **,** please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	#VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2000	8
	2001	9
	2002	10
	2003	11
	2004	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Parents & Friends of the SLC COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0026773

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,317 B. General Construction Type: Exterior Brick and Frame Frame Protected Non Combus Number of Stories single

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

SLC Enrichmnet Center-to provide recreational opportunities to the servere and profound developementally disable individual

This is a gymnasium (with no beds)

Square footage--7,528

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care		1979	$ 999	1
2					2
3	TOTALS			$ 999	3

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	100		1982	1982	$ 3,000,000	$ 100,000	30	$ 100,000	$	$ 1,289,315	4
5			1984	1984	303,400	10,113	30	10,113		213,227	5
6			1984	1984	33,537		15			33,537	6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1978	17,185		15			17,185	9
10	Various Improvements			1979	18,581		20			18,581	10
11	Metal Heater Pads-all pods			1981	5,815		15			5,815	11
12	Sport Court			1982	7,239		10			7,239	12
13	Playground Equipment			1982	10,364		10			10,364	13
14	Storage Building			1982	8,927		15			8,927	14
15	Water Heater-Pod 3			1984	2,065		15			2,065	15
16	Draperies-All Pods and Core Building			1984	22,352		10			22,352	16
17	Drainage System			1984	23,286		10			23,286	17
18	Concrete Sport Court			1984	6,564		10			6,564	18
19	Sidewalk-Core Building to Pod 2 and 3			1984	1,050		10			1,050	19
20	Sidewalk-ERC to Maintenance Building			1984	1,632		10			1,632	20
21	Various Trees			1984	5,600		10			5,600	21
22	Parking Lot-Gravel ERC			1985	1,247		10			1,247	22
23	Asphalt Running Track			1985	8,185		10			8,185	23
24	Door/ERC Building			1985	564	19	30	19		382	24
25	ERC Walk and Curb			1985	3,020		10			3,020	25
26	Pine Pavilion			1985	11,542		15			11,542	26
27	Security Alarm			1985	868		15			868	27
28	Gym Dividers			1985	1,600		5			1,600	28
29	Storage Shelves-Gym			1985	1,010		5			1,010	29
30	Central Vacuum System-All Building			1985	7,680		10			7,680	30
31	Drapes for Core Building			1985	3,031		10			3,031	31
32	Faucets			1985	2,160	103	20	103		2,155	32
33	Power Mixer Valve-Core Building			1985	561		10			561	33
34	ERC Parking Lot			1984	2,176		10			2,176	34
35	Reading Lights-All Pods			1985	1,689		10			1,689	35
36	Seidewalk-Core Building to ERC			1984	1,900		10			1,900	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Light Fixtures-All Pods	1985	$ 145	$	10	$	$	$ 145	37
38	Power Panel/Fire Alarm	1985	1,285	63	10	63		1,285	38
39	Bathroom Fixtures-All Pods	1985	2,050		10			2,050	39
40	Fire Alarm System	1986	4,901	245	20	245		4,799	40
41	Windows-Pod Replacement	1986	244		10			244	41
42	Landscaping	1986	892		10			892	42
43	Power Mixer Valve-Core Building	1986	214		10			214	43
44	Bathroom Vanities-All Pods	1986	465		10			465	44
45	Overhead Basketball Goal	1986	3,422		10			3,422	45
46	Draperies-Core Building (Business Office)	1986	254		10			254	46
47	Remodel Visitor Room-Core Building	1986	646		10			646	47
48	Light Fixtures-All Pods	1988	1,162		10			1,162	48
49	Heat Booster-Pod 5	1988	712		10			712	49
50	Door Pump/Motor-Core Building Electric Door	1988	858		10			858	50
51	Marble Counter Tops-All Pods	1989	1,818		10			1,818	51
52	Chrome Lava Faucets-All Pods	1989	1,800		10			1,800	52
53	Back Flow Preventor-Core Building (Waterlines)	1989	1,293		10			1,293	53
54	Booster Heater-Pod 7	1989	779		10			779	54
55	Water Heater-Pods 6 (booster)	1990	760		10			760	55
56	Repair A/C (Core Building)	1990	2,198		5			2,198	56
57	Repair A/C-pod 5	1990	1,239		5			1,239	57
58	New A/C-Pod 3	1990	3,525		10			3,525	58
59	Water Heater-Pod 2	1990	1,522		10			1,522	59
60	Water Heater-Pod 4 (Booster)	1990	760		10			760	60
61	Solid Core Doors-Pod 5	1990	619		10			619	61
62	Water Heater-Pod 6	1990	820		10			820	62
63	Water Heater-Pod 7	1991	1,592		10			1,592	63
64	Water Heater-Pod 3 (Booster)	1991	810		10			810	64
65	Circuit Breaker Box-Core Building	1991	679		10			679	65
66	A/C Unit-Compressor-Pod 2	1991	975		10			975	66
67	A/C Unit-Compressor-Pod 5	1991	1,285		10			1,285	67
68	Fire Safety/Smoke Detectors-All Pods	1992	864		10			864	68
69	A/C Unit-Pod 7 (Unit 2)	1992	3,642		10			3,642	69
70	TOTAL (lines 4 thru 69)		$ 3,559,060	$ 110,543		$ 110,543	$	$ 1,757,913	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,559,060	$ 110,543		$ 110,543	$	$ 1,757,913	1
2	A/C Unite-Pod 4 (Unit 1)	1992	3,642		10			3,642	2
3	Vanities/pod Bathrooms-All Pods	1992	3,305		10			3,305	3
4	Electric Heaters-Pod 2 (Boosters)	1992	810		10			810	4
5	Water Heaters-Pod 2 and 4	1993	5,491		10			5,491	5
6	A/C Unit-Pod 2 (Unit 1)	1993	3,642		10			3,642	6
7	Windows-Pod Replacement	1991	400		10			400	7
8	Painted all pods-Labor/Material	1994	10,644		5			10,644	8
9	Additional Smoke Detectors-All Pods	1994	575		10			575	9
10	Various Corrections to Code	1994	1,097		10			1,097	10
11	Water Heater-Pod 5 (Booster)	1994	860		10			860	11
12	Water Heater-Pod 6	1995	1,950	49	10	49		1,950	12
13	A/C Unit-Pod 6 (Unit 2)	1995	3,953	296	10	296		3,953	13
14	A/C Unit-ERC (Classroom)	1996	1,774	133	10	133		1,774	14
15	Carpeting-All Pods	1996	38,806		7			38,806	15
16	Painted Pods/Touched Up (Labor and Materials)	1996	3,356		5			3,356	16
17	Water Heater-Pod 5	1996	2,032	203	10	203		1,896	17
18	Booster Heater-Pod 5	1996	951	95	10	95		888	18
19	Booster Heater-Spare	1997	952	95	10	95		920	19
20	Carpeting-Core Building	1997	6,041		7			6,041	20
21	Water Heater Booster-Dietary	1997	1,585		7			1,585	21
22	Walk in Freezer Repairs	1998	1,590	76	7	76		1,590	22
23	Water Heater-120 Gallon	1998	2,152	282	7	282		2,152	23
24	Water Heater-120 Gallon	2000	2,256	322	7	322		1,772	24
25	Gymansium Roof	2000	21,635	1,442	15	1,442		7,332	25
26	Renovation of Pod 2	2001	66,904	9,558	7	9,558		47,789	26
27	Renovation of Pod 4	2001	7,746	1,107	7	1,107		4,703	27
28	Fire Supression System-Dietary	2002	2,740	391	7	391		1,206	28
29	Water Softener System	2004	1,960	280	7	280		560	29
30	Condensing Unit (3 1/2 ton)	2004	742	106	7	106		159	30
31	A/C Unit-Pod 2	2004	4,261	609	7	609		863	31
32	A/C Compressor Unit (Core Building)	2004	14,839	2,120	7	2,120		3,003	32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,777,751	$ 127,707		$ 127,707	$	$ 1,920,677	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 137,046	$ 17,078	$ 17,078	$	5	$ 81,280	71
72	Current Year Purchases	36,772	3,066	3,066		5	3,066	72
73	Fully Depreciated Assets	338,734					338,734	73
74								74
75	TOTALS	$ 512,552	$ 20,144	$ 20,144	$		$ 423,080	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	1999 Dodge Mini Van	1999	$ 15,004	$	$	$	5	$ 15,004	76
77	Patient Care	2000 Used Riding Mower	2001	750	150	150		5	650	77
78	Patient Care	1991 Chevy Astro Van-w/c lift	2002	10,130	2,026	2,026		5	7,935	78
79	Patient Care	1991 Chevy Van-w/c lift	2002	7,000	1,400	1,400		5	4,433	79
80	TOTALS			$ 32,884	$ 3,576	$ 3,576	$		$ 28,022	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,324,186	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 151,427	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 151,427	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,371,779	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description: (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [X] YES
   - [ ] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [X]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA 44

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [X]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA 86

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)	882	6,535		7,417
4	Clinical Wages (b)		56,675		56,675
5	In-House Trainer Wages (c)	3,111	25,171		28,282
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$ 3,993	$ 88,381	$	$ 92,374
10	SUM OF line 9, col. 1 and 2 (e)	$ 92,374			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$ N/A

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	32
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	4
2. From other facilities (f)	
TOTAL TRAINED	36

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care	10/3	visits		113	5,105		113	5,105	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	113	$ 5,105	$	113	$ 5,105	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Parents & Friends of the SLC **#** 0026773 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 735,797	$ 735,797	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	684,909	684,909	3
4	Supply Inventory (priced at cost)	9,247	9,247	4
5	Short-Term Investments			5
6	Prepaid Insurance	17,715	17,715	6
7	Other Prepaid Expenses	1,514	1,514	7
8	Accounts Receivable (owners or related parties)	130,956	130,956	8
9	Other(specify): NAT reimbursement	20,547	20,547	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,600,685	$ 1,600,685	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	3,409,608	3,409,608	14
15	Leasehold Improvements, at Historical Cost	440,814	440,814	15
16	Equipment, at Historical Cost	628,598	628,598	16
17	Accumulated Depreciation (book methods)	(2,517,389)	(2,517,389)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,961,631	$ 1,961,631	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,562,316	$ 3,562,316	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 79,027	$ 79,027	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,600	3,600	29
30	Accrued Salaries Payable	235,348	235,348	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	447	447	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 318,422	$ 318,422	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,900	3,900	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,900	$ 3,900	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 322,322	$ 322,322	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,239,994	$ 3,239,994	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,562,316	$ 3,562,316	48

***(See instructions.)**

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,635,014	1
2	Restatements (describe):		2
3	**inclusion of building cost that was warranted to SLC**	1,766,229	3
4	**in 1982 and was never reflected on the balance sheet**		4
5	**previously. (See audit report for tie-in)**		5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,401,243	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(161,249)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (161,249)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,239,994	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,897,928	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,897,928	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	35,720	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 35,720	23
	D. Non-Operating Revenue		
24	Contributions	5,715	24
25	Interest and Other Investment Income***	15,180	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 20,895	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	insurance settlement, garnishment fees and	17,942	28
28a	miscellaneous income		28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 17,942	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,972,485	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	782,980	31
32	Health Care	2,081,735	32
33	General Administration	880,173	33
	B. Capital Expense		
34	Ownership	153,800	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	235,046	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,133,734	40
41	**Income before Income Taxes (line 30 minus line 40)****	(161,249)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (161,249)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,393	1,512	$ 39,482	$ 26.11	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	14,853	15,870	271,987	17.14	4
5	CNAs & Orderlies					5
6	CNA Trainees	8,104	8,104	64,092	7.91	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,613	1,761	16,565	9.41	8
9	Activity Director	1,479	1,581	23,137	14.63	9
10	Activity Assistants	1,061	1,177	9,589	8.15	10
11	Social Service Workers	1,776	2,027	23,304	11.50	11
12	Dietician					12
13	Food Service Supervisor	3,742	4,214	55,873	13.26	13
14	Head Cook	3,559	4,077	39,030	9.57	14
15	Cook Helpers/Assistants	1,652	1,659	13,998	8.44	15
16	Dishwashers	11,565	12,292	92,131	7.50	16
17	Maintenance Workers	5,607	6,161	63,363	10.28	17
18	Housekeepers	14,295	14,744	139,661	9.47	18
19	Laundry					19
20	Administrator	1,856	2,160	58,778	27.21	20
21	Assistant Administrator	868	1,030	17,605	17.09	21
22	Other Administrative	3,733	4,413	66,533	15.08	22
23	Office Manager	1,472	1,930	34,910	18.09	23
24	Clerical	1,868	2,074	21,107	10.18	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	6,588	7,070	97,642	13.81	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	125,818	138,347	1,324,109	9.57	30
31	Medical Records	1,769	2,011	18,338	9.12	31
32	Other Health Ca CNA training coor	1,423	1,647	28,282	17.17	32
33	Other(specify) seamstress	1,200	1,280	9,267	7.24	33
34	TOTAL (lines 1 - 33)	217,294	237,141	$ 2,528,783 *	$ 10.66	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	169	$ 7,614	1/3	35
36	Medical Director	96	16,080	9/3	36
37	Medical Records Consultant				37
38	Nurse Consultant	38	825	10/3	38
39	Pharmacist Consultant	72	2,115	10/3	39
40	Physical Therapy Consultant	75	3,763	10/3	40
41	Occupational Therapy Consultant	211	10,550	10/3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	110	6,613	10/3	43
44	Activity Consultant				44
45	Social Service Consultant	24	1,440	12/3	45
46	Other(specify) Psychologist	300	19,788	10/3	46
47	Psychiatrist	48	4,200	10/3	47
48					48
49	TOTAL (lines 35 - 48)	1,143	$ 72,988		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	139	4,647	10/3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	139	$ 4,647		53

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Chad M. Rollins	Administrator	0	$ 58,778
Melissa Sauerwein	Asst. Administrator	0	17,605
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 76,383

B. Administrative - Other

Description	Amount
Bank Charges	$ 1,160
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,160
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Gallop, Johnson and Neuman	legal services	$ 3,471
Rice, Sullivan and Co., Ltd	audit services	10,179
SIDC	payroll services	4,564
Nancy Montague	accounting services	3,150
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 21,364

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 35,031
Unemployment Compensation Insurance	2,441
FICA Taxes	190,627
Employee Health Insurance	217,527
Employee Meals	69,588
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	5,519
Employee Gifts/Relations	3,141
TOTAL (agree to Schedule V, line 22, col.8)	$ 523,874

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,000
Advertising: Employee Recruitment	3,142
Health Care Worker Background Check	
(Indicate # of checks performed 64)	992
Illinois Health Care Association dues	5,520
(less 32.97% lobbying costs)	(1,820)
Professional Subscriptions and dues	972
Administrator's license renewal	100
City licensing fee and annual reports	45
Non allowable advertsing/expenses	330
Less: Public Relations Expense	( )
Non-allowable advertising	(330)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,951

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,676
Seminar Expense	3,171
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,847

**See instructions.

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: Ending:

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 1/1/2005 Ending: #

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **yes**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Illinois Health Care Assoc. $5520.**

(3) Did the nursing home make political contributions or payments to a political action organization? **no** If YES, have these costs been properly adjusted out of the cost report? **n/a**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity? **n/a**

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **5 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **20,182** Line **10/2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease. **n/a**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
n/a

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **235,046**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **n/a**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **69,588** Has any meal income been offset against related costs? **n/a** Indicate the amount. $ **n/a**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **n/a**
c. What percent of all travel expense relates to transportation of nurses and patients? **99%**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Rice Sullivan and Co., Ltd.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **yes** If no, please explain. **n/a**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Schedule XI, Ownership Costs, Section D, Vehicle Dpreciation

Use	Model, Make and Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
Prior year adj.								169.00
Patient Care	1979 Ford Truck	1982	4,500.00				5	4,500.00
Patient Care	Snow Plow	1982	1,465.00				5	1,465.00
Patient Care	1988 Tractor	1988	8,356.00				5	8,356.00
Patient Care	1990 Van w/ w/c lift	1991	19,034.00				4	19,034.00
Patient Care	wheelchair lift	1991	2,885.00				4	2,885.00
Patient Care	1993 Plymouth Van	1993	14,547.00				4	14,547.00
Patient Care	1997 Riding Mower	1997	1,000.00				5	1,000.00
Patient Care	2002 Riding Mower	2002	1,033.00	207.00	207.00		4	758.00
Patient Care	2003 Riding Mower	2003	2,577.00	644.00	644.00		4	1,718.00
Patient Care	1993 Ford Van	2003	16,983.00				5	16,983.00
Patient Care	1991 E150 Ford Van	2004	2,150.00	717.00	717.00		3	717.00
Patient Care	1994 Dodge Caravan	2004	2,150.00	717.00	717.00		3	717.00
Patient Care	Repairs for Chevy Astro	2005	779.00	87.00	87.00		3	87.00
Patient Care	1987 Dodge Pick Up	2005	5,715.00				3	
			83,174.00	2,372.00	2,372.00			72,936.00